GAI09472 S.L.C.

AMENDMENT NO. Calendar No.

Purpose: To reduce waste, fraud, and abuse in the Medicare and Medicaid programs, and to protect Medicare benefits and services provided to America's seniors.

IN THE SENATE OF THE UNITED STATES—111th Cong., 1st Sess.

H. R. 3590

AMENDMENT Nº 2966

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By Coburn
To: Amdt. No. 2786
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Page(s)

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AMENDMENT intended to be proposed by Mr. COBURN to the amendment (No. 2786) proposed by Mr. REID

Viz:

Beginning on page 621, strike line 10 and all that follows through page 1134, line 3, and insert the following:

TITLE III—REDUCING WASTE, FRAUD, AND ABUSE IN MEDICARE AND MEDICAID

SEC. 3001. PREVENTION AND DETECTION OF WASTE, FRAUD, AND ABUSE WITHIN THE MEDICARE AND MEDICAID PROGRAMS.

(a) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary shall develop and implement innovative technologies, systems, and procedures (as described under subsection (b)) to reduce waste, fraud, and abuse under the Medicare and Medicaid programs and ensure that amounts attributed to waste, fraud, and abuse constitute an amount not greater than 5 percent of all funds expended under the Medicare program.

(b) PREVENTION AND DETECTION MEASURES.—For purposes of subsection (a), the technologies, systems, and procedures to be developed and implemented by the Secretary shall include the following:

(1) Improving the Medicare beneficiary identifier (MBI) used to identify beneficiaries under the Medicare program to—

(A) ensure that the social security account numbers assigned to such beneficiaries are not used;

(B) provide such beneficiaries with machine-readable identification cards that employ a unique patient number; and

(C) establish a process for changing the MBI for an individual to a different identifier in the case of the discovery of fraud, including identity theft.

(2) Comprehensive real-time data matching across Federal agencies (similar to measures employed by the credit card industry) that is able to determine—

(A) whether a beneficiary under the Medicare or Medicaid programs is dead, imprisoned, or otherwise not eligible for benefits under such programs; and

(B) whether a provider of services or a supplier under the Medicare or Medicaid programs is dead, imprisoned, or otherwise not eligible to furnish or receive payment for furnishing items and services under such programs.

(3) Imposition of direct financial penalties to facilities receiving funds under the Medicare or Medicaid programs that employ any physician, executive, or administrator that has been convicted of an of-

fense involving fraud relating to the Medicare or Medicaid programs or reached a settlement relating to such an offense with the Federal Government or any State government.

(4) Use of procedures and technology (including front-end, pre-payment technology similar to that used by hedge funds, investment funds, and banks) to provide real-time data analysis of claims for payment under the Medicare program to identify and investigate unusual billing or order practices that could indicate fraud or abuse.

(c) INVESTIGATION.—The Secretary shall, in the case where a provider of services or a supplier under the Medicare or Medicaid programs submits a claim for payment for items or services furnished to an individual who the Secretary determines, as a result of information obtained pursuant to subsection (b), is not eligible for benefits under such program, or where the Secretary determines, as a result of such information, that such provider of services or supplier is not eligible to furnish or receive payment for furnishing such items or services, refer the matter to the Inspector General of the Department of Health and Human Services for investigation not later than 14 days after the Secretary has made such a determination.

(d) DEFINITIONS.—In this title:

(1) MEDICAID.—The term "Medicaid" means the program for medical assistance established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(2) MEDICARE.—The term "Medicare" means the program for medical assistance established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(3) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

SEC. 3002. REINVESTMENT OF SAVINGS INTO MEDICARE PROGRAM.

Any savings achieved under the Medicare program pursuant to the measures developed and implemented by the Secretary under section 3001 shall be reinvested into the Federal Hospital Insurance Trust Fund, as established under section 1817 of the Social Security Act (42 U.S.C. 1395i), or the Federal Supplementary Medical Insurance Trust Fund, as established under section 1841 of such Act (42 U.S.C. 1395t).

SEC. 3003. USING HEALTH CARE PROFESSIONALS TO REDUCE FRAUD.

(a) IN GENERAL.—The Secretary shall establish a demonstration project that uses practicing health care

professionals to conduct undercover investigations of other health care professionals.

(b) DEMONSTRATION PROJECT.—

(1) IN GENERAL.—The Secretary, in coordination with the Office of the Inspector General of the Department of Health and Human Services (referred to in this section as the "Inspector General"), shall establish a demonstration project in which the Secretary enters into contracts with practicing health care professionals to conduct investigations of health care providers that receive reimbursements through any Federal public health care program.

(2) SCOPE.—The Secretary shall conduct the demonstration project under this section in States or regions that have—

(A) above-average rates of Medicare fraud; or

(B) any level of Medicaid fraud.

(c) ELIGIBILITY.—To be eligible to receive a contract under subsection (b)(1), a health care professional shall—

(1) be a licensed and practicing medical professional who holds an advanced medical degree from an accredited American university or college and has experience within the health care industry; and

(2) submit to the Secretary such information, at such time, and in such manner, as the Secretary may require.

(d) ACTIVITIES.—Each health care professional awarded a contract under subsection (b)(1) shall assist the Secretary and the Inspector General in conducting random audits of the practices of health care providers that receive reimbursements through any Federal public health care program. Such audits may include—

(1) statistically random visits to the practices of such health care providers;

(2) attempts to purchase pharmaceutical products illegally from such health care providers;

(3) purchasing durable medical equipment from such health care providers;

(4) hospital visits; and

(5) other activities, as the Secretary determines appropriate.

(e) FOLLOW-UP BY THE INSPECTOR GENERAL.—The Inspector General shall follow up on any notable findings of the investigations conducted under subsection (d) in order to report fraudulent practices and refer individual cases to the appropriate State and local authorities.

(f) LIMITATION.—The Secretary shall not contract with a health care professional if, due to physical prox-

imity or a personal, familial, proprietary, or monetary relationship with such health care professional to individuals that such professional would be investigating, a conflict of interest could be inferred.

(g) FUNDING.—To carry out this section, the Secretary and the Inspector General are each authorized to reserve, from amounts appropriated to the Department of Health and Human Services and the Office of the Inspector General of the Department of Health and Human Services, respectively, $500,000 for each of fiscal years 2010 through 2014.